North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

3001 Mail Service Center • Raleigh, North Carolina 27699-3001

Tel 919-733-7011 • Fax 919-508-0951

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

Michael Moseley, Director

September 22, 2005

MEMORANDUM

To:
Legislative Oversight Committee Members
Commission for MH/DD/SAS
Consumer/Family Advisory Committee Chairs
State Consumer Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Board Chairs
North Carolina Council of Community Programs
State Facility Directors
Area Program Directors
Area Program Board Chairs
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

From: Mike Moseley

Re: **Communication Bulletin #048**
Service Transition Guidance – How to Use Existing Definitions in Transition: Mobile Crisis Management

State Plan Communication Bulletin

As we move closer to the implementation and transition of new or modified Enhanced services, we would like to provide guidance on how Mobile Crisis Management may be offered and reimbursed during this transition period. The combination of existing service definitions and billing codes will afford providers reimbursement for delivering mobile crisis. It is equally important for providers who plan to deliver this service to fully meet the requirements identified in the Mobile Crisis Management definition (currently awaiting CMS approval) and go through the necessary endorsement process (see Communication Bulletin #44).

Again, thank you for your efforts to facilitate a smooth and coordinated transition for implementing the best possible array of services and supports for consumers and families in your communities. Should you have questions or comments, please contact Dr. Michael Lancaster at (919) 733-7011 or via electronic mail at Michael.Lancaster@ncmail.net.

Attachments

cc:
Secretary Carmen Hooker Odom
Dr. Allen Dobson
Allyn Guffey
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMH/DD/SAS Staff
Rob Lamme
Rich Slipsky
Wayne Williams
Kaye Holder
Coalition 2001 Chair

Transition Plan for Mobile Crisis Management

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance are proposing a transitional plan to begin to develop community capacity in Mobile Crisis Management that will reflect services available under the new definition pending approval at the Centers for Medicare and Medicaid Services (CMS). This transition plan will allow for billing of Mobile Crisis Management using the existing service codes as a way to provide this service until the new definition is in place. The following guidelines and definitions are provided to support and encourage Local Management Entities and providers to combine allowable expenditures of state and federal service funds for Mobile Crisis Management.

There has been an increase the number of admissions at all State psychiatric hospitals in North Carolina. This has been in part due to the lack of available community resources and capacity to respond to clients' crises or emergency needs... The new service definitions using Mobile Crisis Management will be an important step in developing resources to support consumers in their communities and reduce the admission rate in local hospitals and state psychiatric hospitals. The goal would be to develop Mobile Crisis Management for providers using the transition plan (as described below) while the new service definition is being approved by CMS.

Included in this transmittal is the following information:

1. The proposed new service definition for Mobile Crisis Management that has been sent to CMS for approval. While this is not the final definition, it is not expected to have significant changes. Programs should use this definition as a model for developing Mobile Crisis Management in the community.
2. Current services that are under DMA and DMH/DD/SAS to be billed as a bundled service to create the Mobile Crisis Management model during this transition period
3. Policy Guidance excerpt on Mobile Crisis Management & Kentucky as a promising model of Mobile Crisis Service.

Current Services to be bundled for Mobile Crisis:

Billing:

Service Definitions	**Billing Codes**
Assertive Outreach* (homeless/ deaf & hard of hearing only)	YP230,
Evaluation /Screening	90801, H0001; H0031,
Medication Check	90862
Case Support*	YP215,
Community Psychiatric Supportive Treatment (Community Based Services)	H0036 HI, H0036 HM
Evaluation & Management	99201-99205, 99211-99215
Targeted Case Management (CAP MR/DD only)	T1017 HI
Case Management	T1017 HE

*** State Service**

> Mobile Crisis Management: An LME may contract with a service provider or hospital to provide this service. It may be linked to law enforcement for cases such as suicide attempts or domestic violence. This service is primarily delivered face to face with the client and in locations outside the agency's facility. It includes crisis prevention and supports designed to reduce the incidence of recurring crises and should be specified in a person's crisis plan. Usually most cost effective in an urban setting, this service is usually delivered by a team of MH/SA professionals. This is a Medicaid second level billable service available 24/7/365 for mental health, Developmental Disability, and substance abuse clients.
>
> ---*Policy Guidance, p12*
> *Communication Bulletin #35*

The DMH/DD/SAS Policy Guidance-Development of Community Based Crisis Stabilization Services gives a vast array of service options for specific geographical locations (see table 4, page 13), this information is to be used as a tool for planning and not to limit any one LME that would like to create the service for its area, be it rural or urban. More specifically, Mobile Crisis Management is a service mostly found in urban areas, however it can also be particularly useful in meeting the needs of rural communities that have significant barriers to treatment to include the lack of public transportation, lack of available mental health emergency response in a timely fashion, and the significant distance to get to a facility based crisis center or emergency department for evaluation. In implementing Mobile Crisis Management, LMEs should ensure that it meets the minimum Medicaid requirements if providers expect to receive Medicaid reimbursement for the service.

Mobile crisis service is considered an integral part of an effective emergency mental health system (*Guo, S, et al, 2001)* and thought to reduce admission rates at hospitals by diverting patients from hospital admission into community based treatment. Mobile crisis response is distinguished by the perception of urgency surrounding the referral and the capability of the agency providing the service to respond in a consistently rapid fashion. In *Mental Health: A Report of the Surgeon General* stated that most mobile crisis teams ….have been proven effective in addressing crisis *and* are available on a 24 hour basis. The presence of a psychiatrist on the team improves medical and psychiatric diagnostic capability and permits involuntary treatment decisions to be made on the spot. Medications may also be initiated in the field. Some mobile crisis teams are based with police departments, community mental health centers, and hospitals. Advantages to mobile crisis include:

- Extending mental health expertise to individuals and agencies that are involved with consumers in crisis in the community
- Mobility is critical in rural areas
- Establish linkages with community agencies and bridge services for consumers.
- Permits "case finding" reducing the likelihood of consumers falling through the cracks
- Early intervention
- Triage and debrief disasters victims

Geller, J, et al (1995) surveyed 39 state mental health agencies reflecting their views where mobile crisis was available indicated that the rates of admission were reduced by more than half. The APA Task Force stated:

> "*Mobile teams can cover wide areas and may be particularly useful in rural communities where mental health services are distant and public transportation is lacking."*[1]

Kentucky has demonstrated that mobile crisis can be successfully provided in rural areas with designated staff on call in each county and when facility based crisis units or other services may be too far away and not timely. While we realize this model is not identical to the model we are implementing in North Carolina, the process of the development of this rural service can serve as an example of how to think about these issues.

Kentucky

Kentucky's mobile crisis units (with specifics from the Kentucky River Region) are built to work in rural regions. In the Kentucky River Region (that covers 8 counties) there is a 1-800 crisis line that responds to calls mainly in the evenings, holidays and weekends. The crisis line operator has a list of clinicians that are "on call" for that particular day. These clinicians are paid a flat fee to carry the pager and be on call, and they are paid an additional "per assessment" fee for each crisis event. The staff is spread across the counties of the region. Each county has a designated site where staff meets the youth/family at a medical hospital or a mental health facility. Consequently, the family travels only a short distance to be seen for assessment. If they need crisis stabilization or hospitalization, the staff ensures that the family can safely transport the child/youth. Occasionally, a judge will sign a transport order if the family needs that, but most of the time the family can get there. There is also on-call staff paid by the hour to drive an agency vehicle to transport the youth with the parent/guardian. There is some staff who are willing to go into the home to assist families, but that is on a case by case basis and is usually established as a part of their crisis plan. The outpatient staff in each county is trained to respond to crises in their communities during the work hours so there should never be a time that a responder is that far away.

[1] APA Task Force, 2002.

References:

American Psychiatric Association Task Force on Psychiatric Emergency Services (2002) *Report and Recommendations Regarding Psychiatric Emergency and Crisis Services: A Review and Model Program Description. Arlington, VA: Author.* Retrieved on January 6, 2005 from http://www.psych.org/edu/other_res/lib_archives/archives/200210.pdf.

Geller, J. L., Fisher, W. H., & McDermit, M. (1995). A national survey of mobile crises services and their evaluation. *Psychiatric Services*, 46 (9), 893-897.

Guo, S., Beigel, D., Johnsen, J., & Dyches, H. (2001) Assessing the impact of community based mobile crisis services on preventing hospitalization. *Psychiatric Services 52(2)*, 223-228.

Hatcher, S., O'Brien, T., Coupe, N., & Charters, G. (2003). *Effective Models of Crisis Mental Health Service Delivery.* The Division of Mental Health Research & Development Strategy.

North Carolina Divisions of Medical Assistance & Mental Health, Developmental Disabilities, and Substance Abuse Services (2005) *Draft Service Definitions and Standards*.

North Carolina Division of Mental Health, Developmental Disabilities, and Substance abuse Services (2005). *Policy Guidance-Development of Community Based Crisis Stabilization Services.*

United States Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.

DRAFT

Mobile Crisis Management (MH/DD/SA)
Medicaid Billable Service

Service Definition and Required Components

Mobile Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Mobile Crisis Management services are available at all times, 24/7/365. Crisis response provides an immediate evaluation, triage and access to acute mental health, developmental disabilities, and/or substance abuse services, treatment, and supports to effect symptom reduction, harm reduction, and/or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports/services. These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability, and appropriate response.

Mobile Crisis Management also includes crisis prevention and supports that are designed to reduce the incidence of recurring crises. These supports and services should be specified in a recipient's Crisis Plan, which is a component of all Person Centered Plans.

Provider Requirements

Mobile Crisis Management services must be delivered by a team of practitioners employed by a mental health/substance abuse/developmental disability provider organization that meets the provider qualification policies and procedures established by DMH and the requirements of 10A NCAC 27I.0208(Endorsement of Providers). These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services .Provider organizations must demonstrate that they meet these standards by either being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Mobile Crisis Management services must be provided by a team of individuals that includes a QP according to 10A NCAC 27G.0104 and who must either be a nurse, clinical social worker or psychologist as defined in this administrative code. One of the team members must be a CCAS, CCS or a Certified Substance Abuse Counselor (CSAC). Each organization providing crisis management must have 24/7/365 access to a board certified or eligible psychiatrist. The psychiatrist **must** be available for face to face or phone consultation to crisis staff. A QP or AP with experience in Developmental Disabilities must be available to the team as well. Paraprofessionals with competency in crisis management may also be members of the crisis management team when supervised by the QP. A supervising professional must be available for consultation when a Paraprofessional is providing services.

DRAFT

All staff providing crisis management services must demonstrate competencies in crisis response and crisis prevention. At a minimum, these staff must have:

- a minimum of one (1) year's experience in providing crisis management services in the following settings: assertive outreach, assertive community treatment, emergency department or other service providing 24/7 response in emergent or urgent situations

AND

- twenty (20) hours of training in appropriate crisis intervention strategies within the first 90 days of employment

Professional staff must have appropriate licenses, certification, training and experience and non-licensed staff must have appropriate training and experience.

Service Type/Setting

Mobile Crisis Management is a direct and periodic service that is available at all times, 24/7/365. It is a" second level" service, in that other services should be billed before Crisis Management, as appropriate and if there is a choice. For example, if the recipient's outpatient clinician stabilized his/her crisis, the outpatient billing code should be used, not crisis management. If a Community Support worker responds and stabilizes his/her crisis, the Community Support billing code should be used.

Units will be billed in fifteen (15) minute increments.

Mobile Crisis Management services are primarily delivered face-to-face with the consumer and in locations outside the agency's facility. Annually the aggregate services that have been delivered by the agency will be assessed for each provider agency using the following quality assurance benchmarks:

- Team providing this service must provide at least eighty percent (80%) of their units on a face-to face with recipients of this service.

If a face-to-face assessment is required, this assessment must be delivered in the least restrictive environment and provided in or as close as possible to a person's home, in the individual's natural setting, school, work, local emergency room, etc. This response must be mobile. The result of this assessment should identify the appropriate crisis stabilization intervention.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Program Requirements

Mobile Crisis Management services should be delivered in the least restrictive environment and provided in or as close as possible to a person's home.

Mobile Crisis Management services must be capable of addressing all psychiatric, substance abuse, and developmental disability crises for all ages to help restore (at a minimum) an individual to his/her previous level of functioning.

DRAFT

Mobile Crisis Management services may be delivered by one (1) or more individual practitioners on the team.

For recipients new to the public system, Mobile Crisis Management must develop a Crisis Plan before discharge. This Crisis Plan should be provided to the individual, caregivers (if appropriate), and any agencies that may provide ongoing treatment and supports after the crisis has been stabilized. For recipients who are already receiving services, Mobile Crisis Management should recommend revisions to existing crisis plan components in Person Centered Plans, as appropriate.

Utilization Management

There is no prior authorization for the first 32 units of crisis services per episode. The maximum length of service is 24 hours per episode. Additional authorization must occur after 32 units of services have been rendered. For individuals enrolled with the LME, the crisis management provider must contact the LME to determine if the individual is enrolled with a provider that should and can provide or be involved with the response. Mobile Crisis Management should be used to divert individuals from inpatient psychiatric and detoxification services. These services are not used as "step down" services from inpatient hospitalization.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the LME (only after the LME is deemed ready by DHHS). If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

The maximum length of service is 24 hours per episode.

Entrance Criteria

The recipient is eligible for this service when:

A. the person and/or family are experiencing an acute, immediate crisis as determined by a crisis rating scale specified by DMH

AND

B. the person and/or family has insufficient or severely limited resources or skills necessary to cope with the immediate crisis

OR

C. the person and/or family members evidences impairment of judgment and/or impulse control and/or cognitive/perceptual disabilities

OR

D. the person is intoxicated or in withdrawal and in need of substance abuse treatment and unable to access services without immediate assistance

Priority should be given to individuals with a history of multiple crisis episodes and/or who are at substantial risk of future crises.

Continued Stay Criteria

The recipient's crisis has not been resolved or their crisis situation has not been stabilized, which may include placement in a facility-based crisis unit or other appropriate residential placement.

DRAFT

Discharge Criteria

Recipient's crisis has been stabilized and his/her need for ongoing treatment/supports has been assessed. If the recipient has continuing treatment/support needs, a linkage to ongoing treatment or supports has been made.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

This service includes a broad array of crisis prevention and intervention strategies which assist the recipient in managing, stabilizing or minimizing clinical crisis or situations. This service is designed to rapidly assess crisis situations and a recipient's clinical condition, to triage the severity of the crisis, and to provide immediate, focused crisis intervention services which are mobilized based on the type and severity of crisis.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. Treatment logs or preprinted check sheets will not be sufficient to provide the necessary documentation. For recipients new to the public system, Mobile Crisis Management must develop a crisis plan before discharge.

Service Exclusions

Assertive Community Treatment, Intensive In-Home Services, Multisystemic Therapy, Medical Community Substance Abuse Residential Treatment, Non-Medical Community Substance Abuse Residential Treatment, Detoxification Services, Inpatient Substance Abuse Treatment, Inpatient Psychiatric Treatment, and Psychiatric Residential Treatment Facility except for the day of admission. Mobile Crisis Management services may be provided to an individual who receives inpatient psychiatric services on the same day of service.

Note:
For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the NC State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.